PATIENT LABEL AREA

PHYSICAL THERAPY AT StLuke's

PATIENT MEDICAL HISTORY
PEDIATRIC REHAB CASE HISTORY

Patient Name: _____ Date: _____

What services are you seeking? ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Feeding Therapy

Date of Birth: _____ Sex: ☐ Male ☐ Female

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Other phone: _____

Please mark which phone is your primary contact number. Person completing this form: _____

Primary Care Physician: _____ Specialist Physicians: _____

_____

Current educational setting/support/services: Please list: _____

_____

Medical History: Please list current medical diagnoses and date of diagnosis: _____

_____

Birth History: Length of pregnancy: _____ Duration of Labor: _____ Delivered via: ☐ Cesarean ☐ Vaginal

Birth Weight: _____ Birth Length: _____ Please list any complications: _____

Did the child require any of the following: NICU: ☐ Yes ☐ No Special Care nursery: ☐ Yes ☐ No

Oxygen: ☐ Yes ☐ No Incubator: ☐ Yes ☐ No ☐ Other: _____

Please list age at which the child was able to do the following: Held Head up: _____ Sat without support: _____

Rolled Over: _____ Crawled: _____ Stood alone: _____ Walked independently: _____ Toilet Trained: _____

Please list other medical history/surgical history/hospitalizations: _____

_____

Has your child had hearing screened? ☐ Yes ☐ No If Yes, what were results? _____

Has your child had vision screened? ☐ Yes ☐ No If Yes, what were results? _____

Please list all medications your child is presently taking: _____

_____

Any allergies? ☐ Yes ☐ No If Yes, please list: _____

Names of other children in the family: Please list names, ages: _____

Names of adults living in the home: Please list relationship: _____

Has anyone in your family needed special education services, therapies, speech services? _____

_____

Have you had any of the following this year? ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy

☐ Early Intervention ☐ Home Care ☐ Feeding Therapy If Yes, where were you treated, when were you treated and for what condition? _____

We will do our best to work with you and your child's schedule; however, we ask for your flexibility to find a consistent time for therapy. Please list your availability for therapy sessions: _____

_____

Please turn over →

Patient's Signature: _____

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Occupational Therapy: ***If you are seeking occupational therapy for your child, please complete this section.***
What are you primary concerns leading to an occupational therapy evaluation? _____

_____

Play Skills: What does your child like to play with? _____
What does your child dislike playing with? _____
Describe your child's attention to structured or unstructured play: _____
How does your child spend unstructured time? _____
Describe your child's social behavior with others? _____
Self Help: Has your child ever used feeding utensils? ☐ Yes ☐ No If Yes, is assistance needed for success?
Please describe: _____
How much assistance in needed with self-dressing? _____
Can your child complete buttons, zipper, snaps? ☐ Yes ☐ No
Can your child independently drink from a cup? ☐ Yes ☐ No

Physical Therapy: ***If you are seeking physical therapy for your child, please complete this section.***
What are you primary concerns leading to an physical therapy evaluation? _____

_____

Has or does the child use braces or orthotics? _____
Has or does the child use any assistance devices? _____
Has the child seen an orthopedic doctor? ☐ Yes ☐ No If Yes, who? _____ When? _____ Why? _____

Speech-Language Therapy: ***If you are seeking speech therapy for your child, please complete this section.***
What are you primary concerns leading to a speech-language evaluation? _____

_____

Hearing: Has your child's hearing appeared normal: ☐ Yes ☐ No If No, please describe _____
Does child respond to soft or moderate sounds? ☐ Yes ☐ No Does child seem to listen to people's voices? ☐ Yes ☐ No
Can child follow instructions which are expected for his/her age? ☐ Yes ☐ No
Does child like to listen to children's stories? ☐ Yes ☐ No
Speech and Language: Please provide age at which started and example for the follow categories:
1. Babbling: _____
2. First words: _____
3. Put 2 words together: _____
4. Put 3-4 words together: _____
5. Sentences: _____
Has the speech progress ever been interrupted or reversed? ☐ Yes ☐ No If Yes, please describe _____

_____
When was the problem with speech/language first noticed? _____
Did it follow an illness, accident or unusual occurrence? _____
Is the child's speech understood by family? ☐ Yes ☐ No People outside of the family? ☐ Yes ☐ No

Required To Be Completed: **What is your primary language?** _____
What is your preferred language? _____

FOR AUTHORIZED USE ONLY

To Be Completed By The Therapist:

Does the patient show signs of or indicate to you that they are currently experiencing any of the following:

Abuse: ☐ Yes ☐ No Neglect: ☐ Yes ☐ No Depression: ☐ Yes ☐ No Suicidal Thoughts: ☐ Yes ☐ No

Therapist's Signature: _____

Print Name: _____

Date: _____ Time: _____

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